

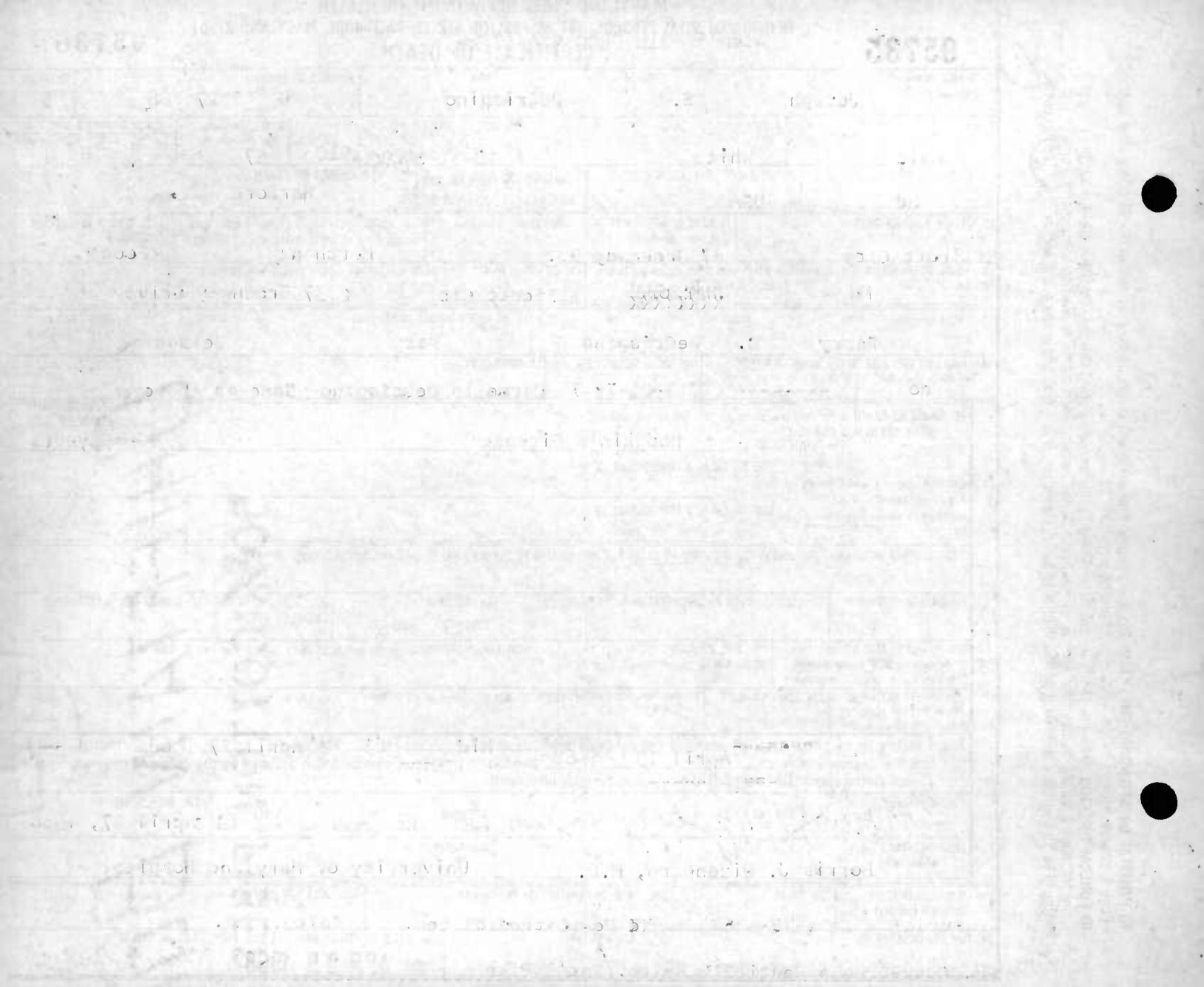
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

05735

35733

1. DECEASED-NAME (Type or print)		First Joseph	Middle S.	Lost DeCrispino		20. DATE OF DEATH 4 Month 27 Day 68 Year	2b. HOUR 5 M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH 10-31-1909		6. AGE (in years last birthday) 57	IF UNDER 1 YEAR MONTHS 0 DAYS 0	IF UNDER 24 HRS. HOURS 0 MIN. 0
7a. BIRTHPLACE (State or foreign country) Md		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED		9. COUNTY OF DEATH Harford Howard		
10. CITY OR TOWN OF DEATH Ellicott City		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 37 Greenway Dr.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Merchant		12b. KIND OF BUSINESS OR INDUSTRY Food		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md		13b. COUNTY Howard		13c. CITY OR TOWN Ellicott City		13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	13e. STREET AND NUMBER 37 Greenway Drive	
14. FATHER'S NAME First Harry		Middle D.	Lost DeCrispino	15. MOTHER'S MAIDEN NAME First Mary		Middle Delbonzo	Lost	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown No		16b. SOCIAL SECURITY NO. 213-01-7967		17. INFORMANT Carmello DeCrispino		Address Same as Above		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hodgkin's Disease Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying cause</u> 201X (b) DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 201X								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.	City or Town	County	State	
22a. I certify that (I) (<u>the hospital</u>) attended the deceased from Mid , 19 63 , to April 27, 1968 , that (I) (<u>we</u>) last saw the deceased alive on April 19 , 19 68 , and that in (my) (<u>our</u>) opinion death occurred on the date and hour and from the causes stated above, (I) (<u>we</u>) (did) (<u>did not</u>) view the body after death.								
22b. SIGNATURE <i>Morris J. Wizenberg, M.D.</i>		DEGREE	ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED April 27, 1968		
22d. PHYSICIAN'S NAME (Type) Morris J. Wizenberg, M.D.		22e. ADDRESS University of Maryland Hospital						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 4-30-1968		23c. NAME OF CEMETERY OR CREMATORIAL ME New Cathedral Cem.		23d. LOCATION (City or Town) Balto., Md.		
24. FUNERAL DIRECTOR ADDRESS Wm. Cook-Brooks West 6212 Balto. Nat'l Pike		25a. REC'D BY REGISTRAR DATE APR 29 1968			25b. REGISTRAR'S SIGNATURE Charles Judge			
MEDICAL CERTIFICATION								

38150



MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05739

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1	DECEASED NAME (Type or print)			First	Middle	Last	20. DATE OF DEATH Month	Doy	Year	2b. HOUR	
	KATIE ELLEN DUVALL						APRIL	23	1968	M	
3. SEX	F	4. RACE	W	S. DATE OF BIRTH	JULY 10, 1872		6. AGE (In years lost birthday)	95	IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS. DAYS	
7a. BIRTHPLACE (State or foreign country)	MD	7b. CITIZEN OF WHAT COUNTRY?	USA	8. MARRIED	NEVER MARRIED	WIDOWED	DIVORCED	9. COUNTY OF DEATH	HOWARD		
10. CITY OR TOWN OF DEATH	SAVAGE	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	110 WASH. ST.	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)	HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY	HOME			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE	MD	13b. COUNTY	HOWARD	13c. CITY OR TOWN	SAVAGE		13d. INSIDE CITY LIMITS?	YES	NO	13e. STREET AND NUMBER	
14. FATHER'S NAME	First	Middle	Last	15. MOTHER'S MAIDEN NAME	First	Middle	Last				
AUGUST		POSTER		UNKNOWN							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16b. SOCIAL SECURITY NO.			17. INFORMANT	ARTHUR A. DUVALL		Address 418 LAUREL AVE LAUREL, MD				
794X										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 794X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a). (b) stating the underlying cause lost.											6 mos.
DUE TO, OR AS A CONSEQUENCE OF (c) 14y.											14y.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(o) 794X											
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?	YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town		County		State				
22a. I certify that (I) (this hospital) attended the deceased from 1/1/68, 19, to 4/23/68, 19, that (I) (we) last saw the deceased alive on 4/23/68, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE	Frank E. Shipley			DEGREE	ATTENDING PHYS.	<input checked="" type="checkbox"/> MED. DIRECTOR	<input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (Type)	FRANK E. SHIPLEY, M.D.			22e. ADDRESS	SAVAGE, MD						
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORIAL SAVAGE Cem.			23d. LOCATION (City or Town)	(County)	(State)				
Burial	4-26-68				SAVAGE	HOWARD	MD				
24. FUNERAL DIRECTOR	ADDRESS			25a. REC'D BY REGISTRAR	25b. REGISTRAR'S SIGNATURE						
He Witt Funeral Home, Laurel Md				APR 30 1968	Judge						

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FOR STATE
HEALTH DEPT

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
05737. MEDICAL EXAMINER'S CERTIFICATE OF DEATH
Any delay is
necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to
the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page
5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or Print)		First JAMES	Middle GRADY	Last GRIFFIN	2a. DATE KNOWN <input type="checkbox"/> Month Day Year DEATH ESTI- MATED <input type="checkbox"/> April 18, 1968	2b. HOUR 11:00 P.M.			
3. SEX Male	4. RACE White	5. DATE OF BIRTH 17 AUG 1918	6. AGE (in years last birthday) 49 YRS	IF UNDER 1 YEAR MONTHS 0	IF UNDER 24 HRS DAYS 0	HOURS 0	MIN. 0	2c. DATE PRONOUNCED DEAD Month April Day 18 , Year 68	2d. HOUR 11:00 P.M.
7a. BIRTHPLACE (State or foreign country) N.C.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Howard						
10. CITY OR TOWN OF DEATH Mt. Airy		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Rt. #3, Mt. Airy, M.D.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) LANDSCAPING			12b. KIND OF BUSINESS OR INDUSTRY NURSERY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Howard	13c. CITY OR TOWN Mt. Airy	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER Rte. #3				
14. FATHER'S NAME FRANK		Middle GRiffin	Last LIZZIE	15. MOTHER'S MAIDEN NAME JOHNSON					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES		16b. SOCIAL SECURITY NO. WW II	17. INFORMANT PUGH FUNERAL HOME, RANDLEMAN, N.C.	ADDRESS					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot wound of Heart DUE TO, OR AS A CONSEQUENCE OF 985 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 919.0									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20. AUTOPSY?				
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year 9:00 A.M. 4-14 1968	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Shot by wife						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Home	21f. LOCATION Street or R.F.D. No. Rte. #3	City or Town Mt. Airy	County Howard	State Maryland			
22o. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input checked="" type="checkbox"/>									
ACTUAL SIGNATURE Edward F. Wilson, M.D.									
EXAMINER'S NAME (Type)		CHIEF MEDICAL EXAMINER <input type="checkbox"/>							
		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>							
		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>							
ADDRESS (Street, city, town, or county)									
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL/REMOVAL APR 24, 1968		23b. DATE APR 24, 1968	23c. NAME OF CEMETERY OR CREMATORIAL RANDOLPH MEMORIAL PARK			23d. LOCATION (City or Town) RANDOLPH COUNTY, N.C.	(County) N.C.	(State) N.C.	
24. FUNERAL DIRECTOR ULLRICH FUNERAL HOME, BALTO, MD.		ADDRESS	25a. RECD BY REGISTRAR			25b. REGISTRAR'S SIGNATURE Charles Judge			
			DATE APR 24, 1968						

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MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

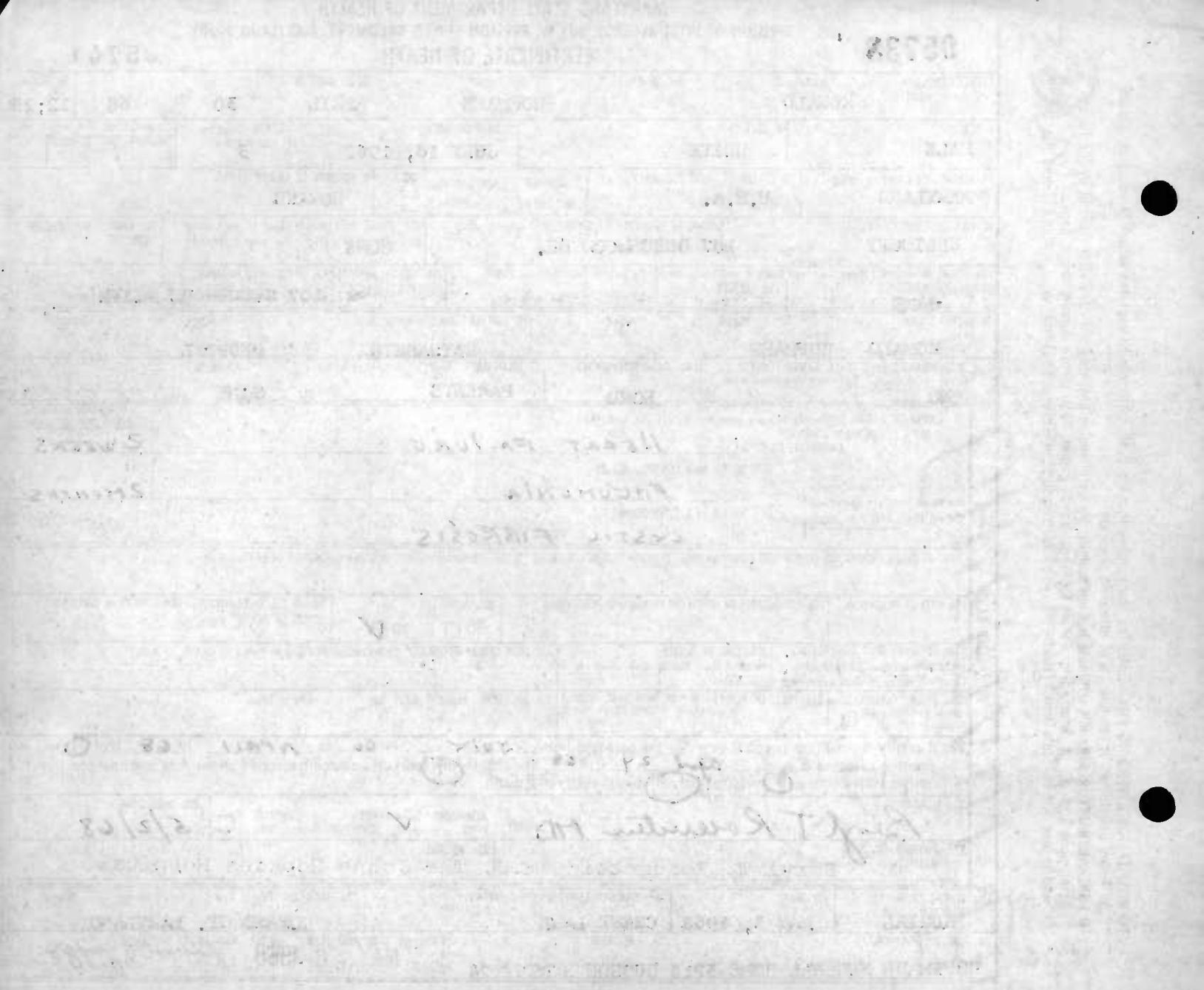
05738

05741

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-tranit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)	First RONALD	Middle HOFMANN	Lost	2a. DATE OF DEATH Month APRIL	Day 50	Year 68	2b. HOUR 12:25
3. SEX MALE	4. RACE WHITE	S. DATE OF BIRTH JULY 16, 1962	6. AGE (In years lost birthday) 5	IF UNDER 1 YEAR MONTHS 5	IF UNDER 24 HRS DAYS 0	HOURS 0	MIN. 0
7a. BIRTHPLACE (State or foreign country) MARYLAND	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED	9. COUNTY OF DEATH HOWARD	Md.			
10. CITY OR TOWN OF DEATH ELLIOTT	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 107 BEECHWOOD DR.	12a. USUAL OCCUPATION (Kind of work done during course of working life, even if retired.) NONE	12b. KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE SAME MD.	13b. COUNTY Howard	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER 107 BEECHWOOD DRIVE			
14. FATHER'S NAME RONALD	First HOFMANN	Middle 	Lost 	15. MOTHER'S MAIDEN NAME ELISABETH	Middle KNOPPEL	Address SAME	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) NO	16b. SOCIAL SECURITY NO. NONE	17. INFORMANT PARENTS	APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 WEEKS				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEART FAILURE 2730 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause (b) PNEUMONIA DUE TO, OR AS A CONSEQUENCE OF (c) CYSTIC FIBROSIS 2893 PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o)							
19a. DATE OF OPERATION 2893	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No.	City or Town	County	State		
22a. I certify that (I) (this hospital) attended the deceased from JULY 1966 , to APRIL 1968 , that (I) (we) last saw the deceased alive on April 24 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Beryl T Rosenstein MD</i>							
22d. PHYSICIAN'S NAME (Type)	DEGREE MD		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS.	22c. DATE SIGNED 5/2/68			
22e. ADDRESS Beryl T. Rosenstein, M.D. The Johns Hopkins Hospital							
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL	23b. DATE MAY 3, 1968	23c. NAME OF CEMETERY OR CREMATORIAL CREST LAWN	23d. LOCATION (City or Town) HOWARD CT. MARYLAND	(County) MARYLAND	(State) MARYLAND		
24. FUNERAL DIRECTOR HOFFMANN FUNERAL HOME 3218 HUDSON STREET	ADDRESS 24	25a. REC'D BY REGISTRAR DATE MAY 6 1968	25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				



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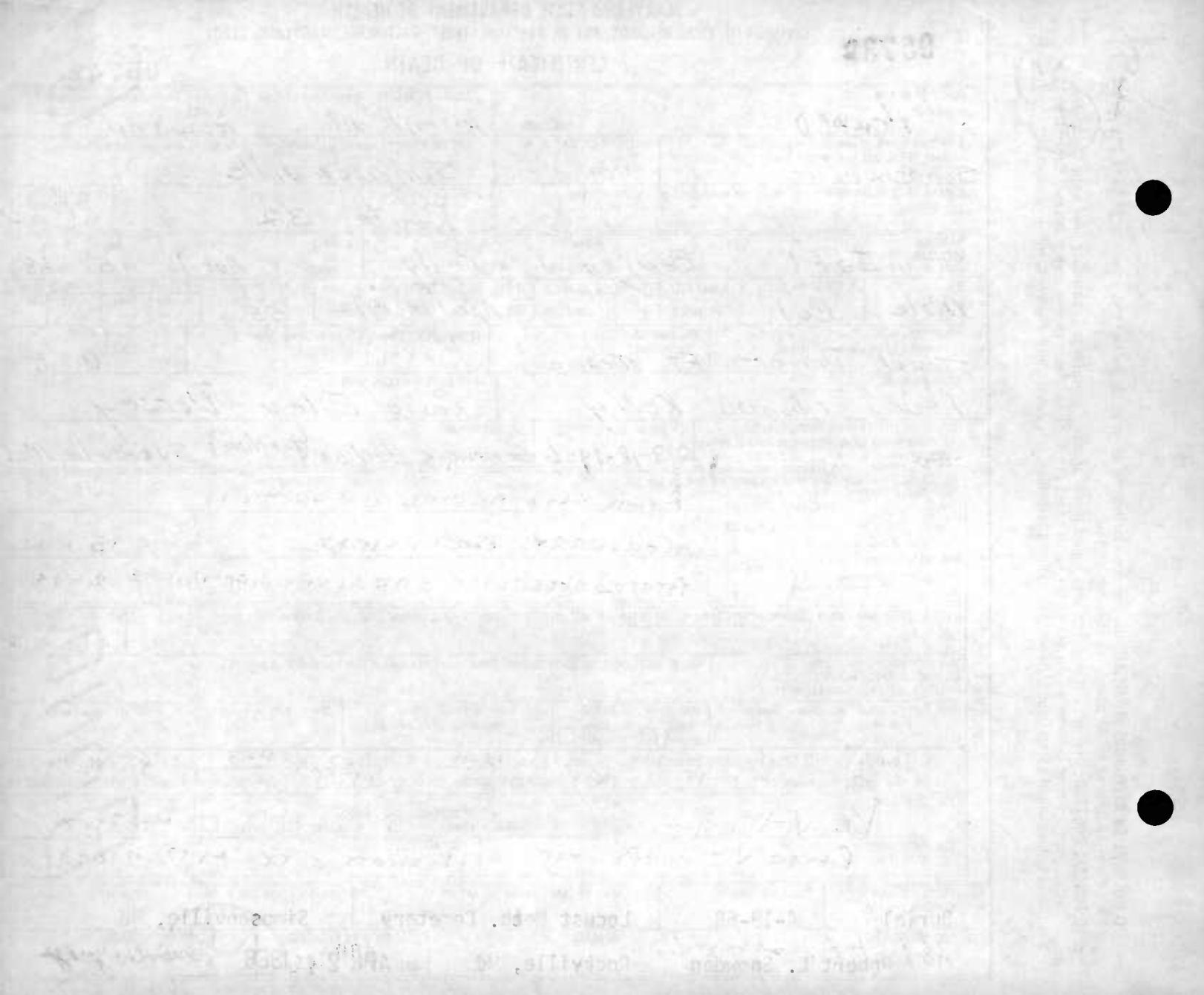
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

05742

HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 4 and 5 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY HOWARD		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE MARYLAND	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SIMPSONVILLE		c. LENGTH OF STAY IN 1b 1/2	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) Earl		First Benjamin	Middle Kelly
4. DATE OF DEATH Month April Day 15 Year 1968	5. SEX Male	6. COLOR OR RACE Col	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>
8. DATE OF BIRTH April 18, 1912	9. AGE (In years last birthday) 55 yrs.	10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Driver	10b. KIND OF BUSINESS OR INDUSTRY FT. Meade
11. BIRTHPLACE (County & State, or foreign country) Maryland	12. CITIZEN OF WHAT COUNTRY? U.S.A.	13. FATHER'S NAME Lewis Thomas Kelly	14. MOTHER'S MAIDEN NAME Rosie Ellen Dorsey
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No	16. SOCIAL SECURITY NO. 213-18-1406	17. INFORMANT Genevieve Hudson (daughter)	Address Sykesville, Md.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4109 DUE TO ACUTE MYOCARDIAL INFARCTION		INTERVAL BETWEEN ONSET AND DEATH 15 MIN.	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CORONARY OCCLUSION DUE TO (c) ATHEROSCLEROTIC CARDIOVASCULAR DISEASE DUE TO		2 YRS.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 4201			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) 20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from 12-11 , 19 65 to 4-15 , 19 68 , that (II) (we) last saw the deceased alive on 4-15 19 68 , and that death occurred on 4-15 19 68 , M, fram causes and on the date stated above.			
22a. SIGNATURE Peter V. Thorpe		22b. DATE SIGNED 4-17-68	
22c. PHYSICIAN'S NAME (Type) PETER V. THORPE MD.		22d. ADDRESS ELLIOTT CITY - MD. 21043	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 4-19-68	23c. NAME OF CEMETERY OR CREMATORIAL Locust Meth. Cemetery
24. FUNERAL DIRECTOR Robert L. Snowden		ADDRESS Rockville, Md	25a. REC'D BY REGISTRAR APR 24 1968
			25b. REGISTRAR'S SIGNATURE Charles Judge



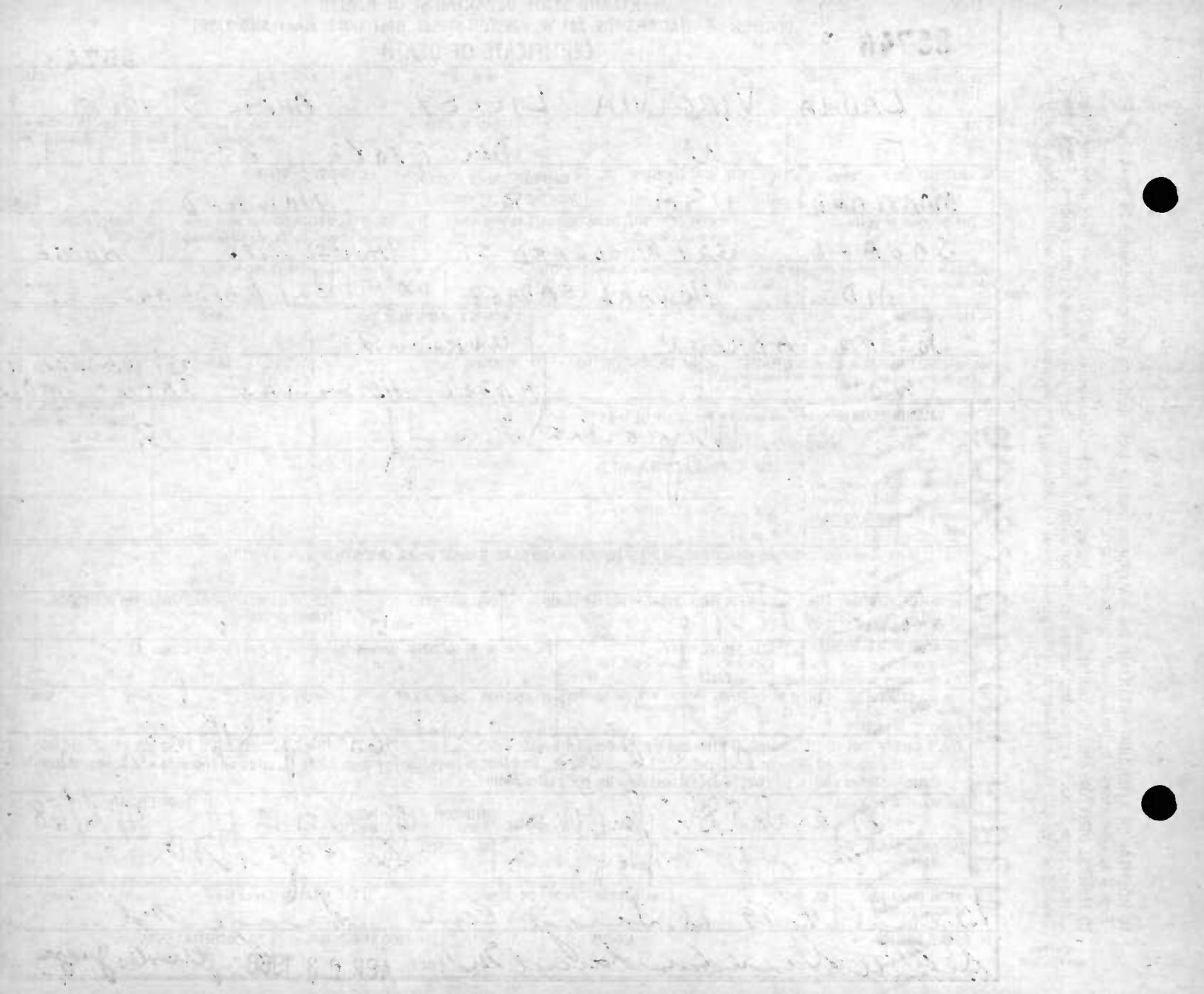
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

05760

05743

10 HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month	Doy	Year	2b. HOUR			
LAURA			VIRGINIA LILLEY			APRIL 16 1968						
3. SEX		4. RACE	5. DATE OF BIRTH			6. AGE (In years last birthday)			IF UNDER 1 YEAR MONTHS	IF UNDER 24 HRS. DAYS	HOURS	MIN.
F		W	DEC 6 1882			85 YRS.						
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH						
MARYLAND		USA				HOWARD						
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY				
SAVAGE		321 Woodward St.			HOUSEWIFE			HOME				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?			13e. STREET AND NUMBER						
MD		HOWARD	SAVAGE			YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	321 Woodward St					
14. FATHER'S NAME		First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last		
JOSEPH		ADREON			UNKNOWN							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.			17. INFORMANT			Address 321 Woodward St SAVAGE, MD				
NO					HAZEL HEISHMAN							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Insuff. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 weeks.												
428X DUE TO, OR AS A CONSEQUENCE OF												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.												
(b) DUE TO, OR AS A CONSEQUENCE OF												
(c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4222												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
None					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from April 1st , 19 68 , to April 11th , 19 68 , that (I) (we) last saw the deceased alive on April 6th , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE		Frank E. Shiley, M.D.			22c. DATE SIGNED	4/6/68						
22d. PHYSICIAN'S NAME (Type)		Frank E. Shiley, M.D.			22e. ADDRESS			Savage, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORIAL			23d. LOCATION (City or Town)		(County)	(State)		
Burial		4-19-68		Savage Cem			Savage Md					
24. FUNERAL DIRECTOR		ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE				
DeWitt Danzedon Laurel Md								Charles Judge				
					DATE APR 23 1968							



FOR STATE
HEALTH DEPT.

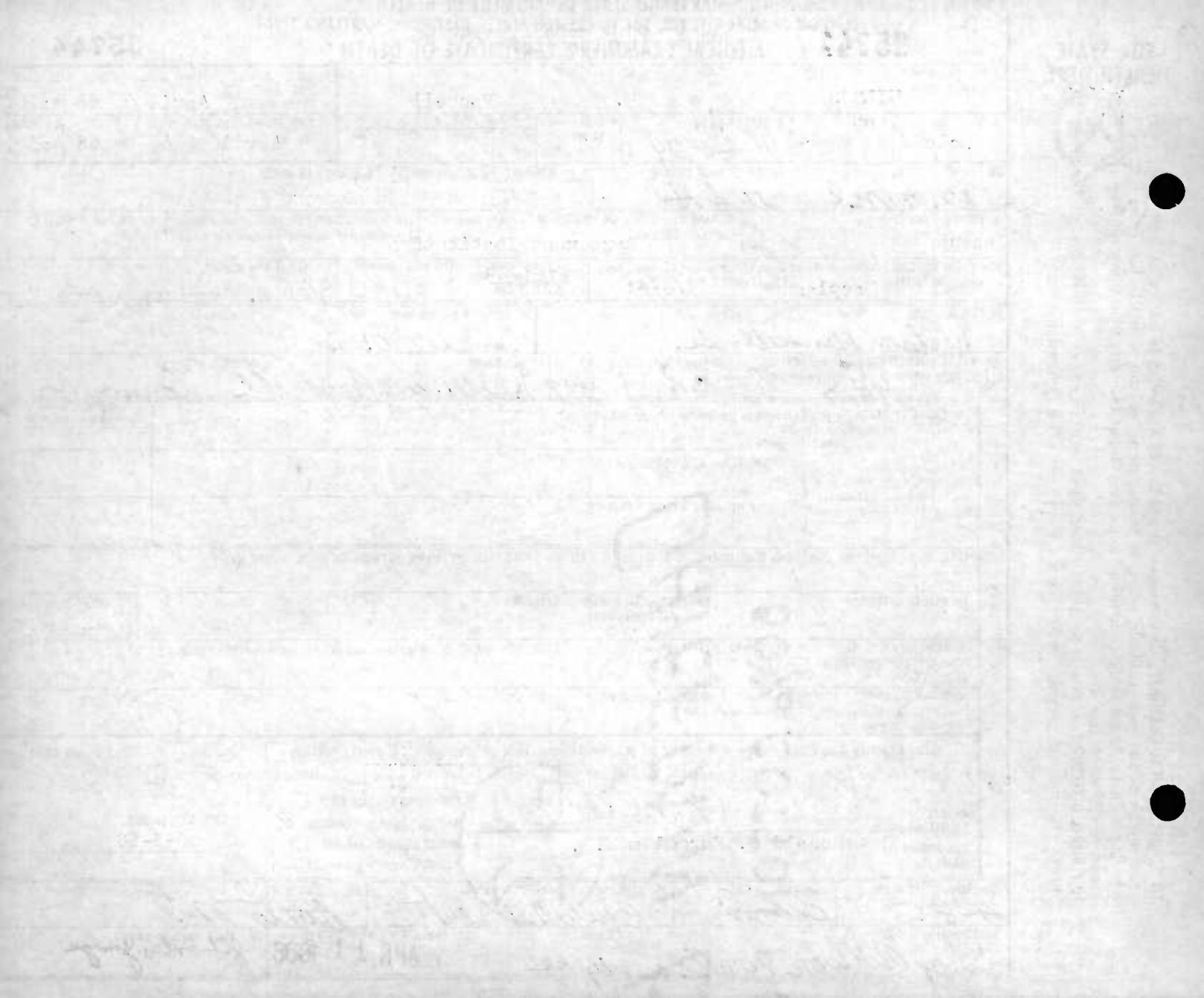
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Item 1. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Dept. of ~~Medic~~

Items 18&22a film 400 MARYLAND STATE DEPARTMENT OF HEALTH
5-1-68 mt DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or Print) WILSON			First	Middle	Lost	2a. DATE KNOWN <input type="checkbox"/> Month Day Year OF ESTI- DEATH MATED <input checked="" type="checkbox"/> April 4, 1968	2b. HOUR 4:10 P.M.
3. SEX Male	4. RACE Negro	S. DATE OF BIRTH 10-20-34	6. AGE (in years last birthday) 43 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD Month April Day 4, Year 1968	2d. HOUR 4:10 P.M.
7a. BIRTHPLACE (State or foreign country) Baltimore		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Howard	
10. CITY OR TOWN OF DEATH Jessup		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Paxtuxent Institution		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Howard		Baltimore	Jessup	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER 3620 W. Garrison Avenue
14. FATHER'S NAME Wilson Pannell Sr.		First	Middle	Last	15. MOTHER'S MAIDEN NAME Gertrude Morris	First	Middle
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) YES		16b. SOCIAL SECURITY NO. 218-12-3837		17. INFORMANT William Pannell	ADDRESS 3620 Jenimoor		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Epilepsy 345.9 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause } last. } (b) DUE TO, OR AS A CONSEQUENCE OF (c)							
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) 3533							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town	County State
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> Actual Signature Ronald N. Kornblum, M.D. Examiner's Name (Type)							
23a. BURIAL, CREMATION, REMOVAL (Specify) 4-8-68		23b. DATE Burial	23c. NAME OF CEMETERY OR CREMATORIAL Burton's Cemetery		23d. LOCATION (City or Town) Baltimore		(County) (State)
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR APR 11 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	



FOR STATE
HEALTH DEPT

Any delay is
necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to
the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with farm PM3. Page
5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of
Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
05742 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

05745

1. DECEASED-NAME (Type or Print)			First	Middle	Last	2a. DATE KNOWN OF ESTI- DEATH MATED	Month	Day	Year	2b. HOUR	
			CHARLES	MONROE	PARHAM	<input type="checkbox"/>	4	23	19 68	3:20 P.M.	
3. SEX	4. RACE	S. DATE OF BIRTH	6. AGE (in years last birthday)			IF UNDER 1 YEAR	IF UNDER 24 HRS.				
Male	White	May 31 1928	39 YRS.			MONTHS	DAYS	HOURS	MIN.		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH				
North Carolina		U.S.A.					Ap Howard			P.M.	
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during time of working, if ever, if retired.)			12b. KIND OF BUSINESS DR INDUSTRY		
Woodstock			Rt. 1 Lee Ramsburg Farm,			Bridgewater			Construction		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?			13e. STREET AND NUMBER		
Md.			Howard			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			Rt. 1 Lee Ramsburg Farm,		
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First	Middle	Last
			Dexter	Parham		Martha			Banham		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO. (If yes give war or dates of service)			17. INFORMANT			ADDRESS		
no			218 20 2297			Vaughn Parham			706 Nottingham Rd. Balto., Md.		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute Acholism APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
571.8 DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause } (b) _____											
stating the underlying cause } DUE TO, OR AS A CONSEQUENCE OF											
last. 5811 (c) _____											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(o)											
Fatty Liver											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY?		
									YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. _____ City or Town _____ County _____ State _____					
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE: <i>Edward F. Wilson</i> M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>											
EXAMINER'S NAME (Type) Edward F. Wilson, M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>											
22b. DATE SIGNED April 23, 1968											
DEPUTY MEDICAL EXAMINER <input type="checkbox"/> ADDRESS(Street, city, town, or county)											
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE 4/26/68		23c. NAME OF CEMETERY OR CREMATORIAL ADDRESS Church of God			23d. LOCATION (City or Town) Lishon			(County) Howard	(State) Md.
24. FUNERAL DIRECTOR John R. Slack		Ellicott City, Md.					25a. REC'D BY REGISTRAR DATE APR 29 1968			25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

21732